Initial Report: Individual Information

*(1) Individual: First Name: Last Name:
*(2) Human Service Coordinator:

*(3) Is the individual on a Level II or Level III Behavior Plan? ☐YES ☐ NO

*(4) Home Address
(4A) Street (4B) City (4C) State

Initial Report: Filing Agency Information

*(5) Filing Agency:
*(6) Was your agency providing services to the individual at the time of the incident? ☐YES ☐ NO ☐ UNKNOWN
*(7) Staff filling out Paper Incident Report:
(8) Staff Responsible for Incident Follow-up:

Initial Report: Incident Classification

*(9A) Date Incident Discovered: *(9B) Approximate Time Incident Discovered:

*(10) Do you know the date and/or approximate time that the incident occurred?

Check one: ☐Both ☐ Date Only ☐ Time only ☐ Neither

Complete only if known
(10A) Date Incident Occurred: (10B) Approximate Time Occurred:

*(11) Did staff directly observe the incident? ☐YES ☐ NO ☐ UNKNOWN
*(12) Was supervision at the time of the incident being provided as assigned? ☐YES ☐ NO ☐ UNKNOWN

(13) Responsible Site:

*(14) Incident Categories: *Check One (** indicates MAJOR Level of Review Required)*

☐ Unexpected/ Suspicious Death ---------- Select
☐ Suicide Attempt ---------- Select
☐ Unexpected Hospital Visit (must complete P. 5) ---------- Select
☐ Sexual Assault ---------- Select
☐ Physical Altercation ---------- Select
☐ Significant Behavioral Incident ---------- No Secondary Category
☐ Missing Person ---------- Select
☐ Medical Intervention Not Requiring a Hospital Visit---------- Select
☐ Fire ---------- Select
☐ Suspected Mistreatment ---------- Select
☐ Property Damage ---------- Select
☐ Theft ---------- Select
☐ Other Criminal Activity ---------- Select
☐ Transportation Accident ---------- Select
☐ Emergency Relocation ---------- No Secondary Category
☐ Unplanned Transportation Restraint ---------- No Secondary Category
☐ Other ---------- No Secondary Category

Individual: First Name: Last Name:

Description of Any Injury Associated with the Incident:

*(15) Is there an Injury? ☐YES ☐NO

If Yes, Complete Questions #16-#19. If No, Skip to #20.

(16) Cause of Injury – **Check all that apply:**

☐ Inflicted by self	☐ Fall	☐ Insect/Animal Bite
☐ Inflicted by staff	☐ Equipment	☐ Motor Vehicle
☐ Inflicted by peer	☐ Restraint-Related	☐ Seizure
☐ Inflicted by other	☐ Transfer/ Handling	☐ Other
☐ Environmental	☐ PICA/ Eating Non-food items	☐ Unknown

(16A) If Other Specify:

(17) Briefly Describe the Injury Including Cause and Factors:

(18) Type of Injury: **Check all that apply**

☐ Abrasion/Cut	☐ Burn	☐ Head Injury	☐ Poison
☐ Bite	☐ Choking	☐ Internal Injury	☐ Puncture
☐ Bruise	☐ Fracture	☐ Other	☐ Sprain/Strain

(18A) If Other Specify:

(19) Body Part Affected by Injury: **Check all that apply**

☐ Toe	☐ Hip	☐ Neck	☐ Ear	☐ Wrist
☐ Foot	☐ Genitals	☐ Head	☐ Mouth	☐ Hand
☐ Ankle	☐ Front Torso	☐ Face	☐ Shoulder	☐ Finger
☐ Knee	☐ Back Torso	☐ Eye	☐ Arm	☐ Other
☐ Leg	☐ Internal Organs	☐ Nose	☐ Elbow	

(19A) If Other Specify:

Initial Report: Incident Description I

*(20) Incident Description: *Describe in detail exactly what happened during the incident. Include dates, times, and all people involved including staff. Include all relevant details prior to, during, and after the incident.*

Initial Report: Incident Description II

*(21) What is the most recent status of the individual?

*(22) Is the incident location known? ☐YES ☐ NO

(22A) Where did the incident occur? Select

(22B) Location Detail: Select

*(22C) Site Location of Incident (address):

(22D) *IF NOT AT PROVIDER SITE, INFORMATION ABOUT INCIDENT LOCATION:*

Location Name/Description:

Location Name and Address, if any:

Individual: First Name: Last Name:

Initial Report: Actions Taken to Protect Health, Safety, and Rights

*(23) Actions Taken to Protect Health/Safety/Rights of the Individual: *Immediate actions taken to protect the individual. Describe administrative, health/safety, treatment and other actions taken to address the incident to date.*

(24) Treatment Provided By: *Check all that apply*

- ☐ Self/ Family
- ☐ Staff (non-medical licensed)
- ☐ LPN, RN, NP
- ☐ EMT
- ☐ MD's Office
- ☐ ER/Crisis Team (no admission)
- ☐ PCA
- ☐ Other (describe above)
- ☐ None

Initial Report: Involved Parties

*(25) People Involved with Incident: (Add additional sheets as needed)

*(25A) Name	*(25B) Involvement **Select all that apply**	*(25C) Relationship **Select all that apply**	(25D) Telephone
	Select	Select	
	Select	Select	
	Select	Select	
	Select	Select	
	Select	Select	

Initial Report: Notification

*(26) Was D.P.P.C. Notified: ☐YES ☐NO –Will Notify ☐ No

(27) Has Family/Guardian Been Notified?: ☐YES ☐ NO – Will Notify ☐ No ☐ N/A

*(28) Was Law Enforcement Involved: ☐YES ☐NO ☐ Unknown

*(29A) Signature of Staff filling out Incident Report:

*(29B) Position:

*(29C) Telephone:

*(29D) Date/Time of Report:

Date Time

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*(30A) Name of Supervisor:

*(30B) Position:

*(30C) Signature of Supervisor:

(30D) Telephone: (30E) Date/Time of Review:

Date Time

DMR Incident Report: Final Report HOSPITAL VISIT

Individual: First Name: Last Name:

Final Report: HOSPITAL VISIT (Complete Only for a Hospital Visit)

(31) Time in ER/Urgent Care/Crisis Unit
☐ <6 Hours ☐ 6-12 Hours ☐ 12-24 Hours ☐ >24 Hours ☐ Unknown

(32) Admission Information: *If not admitted, skip to Question #34*
(32A) Date of Admission: (32B) Hospital Name:
*(32C) Reason for ER/Hospital Visit: *Check One*

☐ Near Drowning ---------- No Secondary Category
☐ Sexual Assault ---------- Select
☐ Physical Altercation ---------- Select
☐ Significant Behavioral Incident ---------- No Secondary Category
☐ Missing Person ---------- Select
☐ Fire ---------- Select
☐ Suspected Mistreatment ---------- Select
☐ Property Damage ---------- Select
☐ Theft ---------- Select
☐ Other Criminal Activity ---------- Select
☐ Transportation Accident ---------- Select
☐ Emergency Relocation ---------- No Secondary Category
☐ Unplanned Transportation Restraint ---------- No Secondary Category
☐ Illness ---------- No Secondary Category
☐ Injury ---------- No Secondary Category
☐ Other ---------- No Secondary Category
☐ Unknown ---------- No Secondary Category

(33) Was the Admission from the ER? ☐ YES ☐ NO
(33A) If yes, did you contact the individual's doctor's office prior to going to the ER?
☐ YES ☐ NO ☐ Unknown
(33B) If yes, did you get an appointment at the doctor's office?
☐ YES ☐ NO ☐ Unknown
(33C) If no, reason for no appointment at doctor's office:
☐ Dr. appointment not available ☐ Other ☐ Unknown

(34) What Occurred During the Hospital Visit? *Check all that apply* Select

(34A) If other, please specify:

(35) Discharge Information: *If not discharged, skip to Question #37*
(35A) Date of Discharge:
(35B) ER/Urgent Care/Crisis Unit/Hospital Discharge Diagnosis: *CHOOSE FROM LIST on following page.*
Discharge diagnosis 1:
Discharge diagnosis 2:
Discharge diagnosis 3:
(35C) *If Other was chosen as a Discharge diagnosis, please specify:*

Individual: First Name: Last Name:

Allergy, Allergic Reaction	Gallbladder problem
Alzheimer's disease	Gastrointestinal bleed
Anemia	Gastrointestinal obstruction
Anxiety/Anxiety Disorder	Gastroesophogeal reflux disease (GERD)
Appendicitis	Glaucoma
Arthritis	Hernia
Asthma	Hypertension/Hypotension
Bipolar Disorder	Infection
Bowel obstruction	Infection, MRSA
Bronchitis	Infection, Urinary Tract
Burn	Infection, Wound or Ostomy
Bursitis	Injury or possible injury
Cancer, blood	Liver toxicity/cirrhosis
Cancer, brain	Medication reaction or side effect
Cancer, breast	Neurological evaluation
Cancer, colon, rectum or anus	Other
Cancer, esophagus	Other, Cardiac
Cancer, kidney	Other, Gastrointestinal
Cancer, liver	Other, Genitourinary
Cancer, lung	Other, Psychiatric
Cancer, other	Pancreatitis
Cancer, pancreas	Parkinson's Disease
Cancer, prostate	Personality Disorder
Cancer, stomach	PICA, ingested foreign object
Cancer, testicular	Pneumonia, Aspiration
Cardiac Arrest	Pneumonia, Influenza
Catheter related	Pneumonia, type unknown
Cellulitis	Poisoning or possible poisoning
Cerebral Palsy	Post-op complications
Chest pain, non-cardiac	Psychiatric, general/unknown
Chest pain, possible cardiac	Renal/Kidney condition
Choking or Aspiration	Respiratory distress or arrest
Congestive Heart Failure	Schizophrenia and thought disorders
Constipation	Sepsis, dental
Chronic Obstructive Pulmonary Disease (COPD)	Sepsis, Respiratory
Dehydration	Sepsis, unknown or other
Dementia	Sepsis, Urinary tract/kidney
Dental condition	Sepsis, wound or ostomy
Diabetes/Blood sugar problem	Skin condition
Dysphagia	Sprain
Ear condition, Inner Ear	Stroke (CVA)
Ear condition, Outer Ear	Substance abuse
Epilepsy / Seizure	Suicidal
Eye condition	Thyroid condition
Fever of Unknown Origin	Ulcer, gastrointestinal
Fracture	Urinary retention
G/J-tube problems	Unknown

Individual: First Name: Last Name:

(35D) Did you get instructions Upon Discharge? ☐YES ☐ NO

(35E) Changes for Individual Upon Discharge: *Check all that apply*

☐ Increase in medication(s) (compared to medications before admission)
☐ Decrease in medication(s)/Discontinuation of medication(s) (compared to medications before admission)
☐ New medication
☐ New Treatment
☐ New instructions received for signs and symptoms
☐ Instructions on when to contact the health care practitioner
☐ Wound Care
☐ New Equipment
☐ Newly diagnosed condition
☐ New living situation (specify in additional information below)
☐ Transferred to rehabilitation or nursing facility
☐ No Change

(36) Current Status: *Check all that apply*
☐ Change in daily living capabilities – lower than before hospitalization
☐ Change in daily living capabilities – higher than before hospitalization
☐ No change in daily living capabilities
☐ New Health status – temporary condition that will get better
☐ New Health status – progressively deteriorating condition
☐ New Health status – permanent condition, not changing
☐ New Health status – terminal condition
☐ Unclear at this time

(37) Specify Any Follow Up Appointments: *Check all that apply*

☐Primary Care Physician (PCP)	☐Outpatient Psychiatrist
☐Admitting Physician	☐Admitting Psychiatrist
☐Surgeon	☐Other (specify in additional information below)
☐Specialist	☐None

(38) Any Additional/Clarifying Information:

Individual: First Name: Last Name:

Final Report: Additional Information

(39) Incident Description: *Any updated or corrected information from the Incident Description (Question 20)including dates, times, people involved, and relevant details prior to, during and after the incident. Indicate the current status of the individual. If law enforcement was involved, please list details of actions taken by law enforcement.*

Final Report: Action Steps

*(40) Are There Additional Action Steps for this Incident: ☐Yes ☐ No

(40A) Action Step:	(40B) Targeted Completion Date:	(40C) Responsible Party: (Name and/or Position)

Final Report:Involved Parties

(41) FOR FINAL REPORT: People Involved with Incident: *Correct only if there are changes from the Initial Report.*

(41A) Name	(41B) Involvement **Select all that apply**	(41C) Relationship **Select all that apply**	(41D) Telephone
	Select	Select	
	Select	Select	
	Select	Select	

Final Report: Verification of the Time and Categorization

*(42) Initial Report Information is correct to the best of my knowledge:

☐Yes *If Yes, Skip this section.*
☐No *If No, Describe any updated or corrected Information below and answer all applicable questions:*

(43) Date and Approximate Time Incident Discovered: Date Time

(44) Do you know the date and/or approximate time that the incident occurred:

Check one: ☐Both ☐ Date Only ☐ Time only ☐ Neither

(44A) Date and Approximate Time Incident Occurred (if known): Date Time

Individual: First Name: Last Name:

*(45) Incident Categories: *Check One (** indicates MAJOR Level of Review Required)*

- ☐ Unexpected/ Suspicious Death ---------- Select
- ☐ Suicide Attempt ---------- Select
- ☐ Unexpected Hospital Visit (must complete P. 5) ---------- Select
- ☐ Sexual Assault ---------- Select
- ☐ Physical Altercation ---------- Select
- ☐ Significant Behavioral Incident ---------- No Secondary Category
- ☐ Missing Person ---------- Select
- ☐ Medical Intervention Not Requiring a Hospital Visit---------- Select
- ☐ Fire ---------- Select
- ☐ Suspected Mistreatment ---------- Select
- ☐ Property Damage ---------- Select
- ☐ Theft ---------- Select
- ☐ Other Criminal Activity ---------- Select
- ☐ Transportation Accident ---------- Select
- ☐ Emergency Relocation ---------- No Secondary Category
- ☐ Unplanned Transportation Restraint ---------- No Secondary Category
- ☐ Other ---------- No Secondary Category

*(46) Was your agency providing services to the individual at the time of the incident? ☐ YES ☐ NO ☐ UNKNOWN

*(47) Staff filling out Incident Report:

(48) Did staff directly observe the incident? ☐ YES ☐ NO ☐ UNKNOWN

(49) Was supervision at the time of the incident being provided as assigned? ☐ YES ☐ NO ☐ UNKNOWN

(50) Was D.P.P.C. Notified: ☐ YES ☐ NO-Will Notify ☐ NO

(51) Has Family/Guardian Been Notified?: ☐ YES ☐ NO-Will Notify ☐ NO ☐ N/A

(52) Was Law Enforcement Involved? ☐ YES ☐ NO ☐ UNKNOWN

Individual: First Name: Last Name:

Description of Any Injury Associated with the Incident:

*(53) Is there an Injury? ☐ YES ☐ NO *If Yes, Complete Questions #54-#57. If No, Skip to #58.*

(54) Cause of Injury: *Check all that apply*

☐ Inflicted by self	☐ Fall	☐ Insect/Animal Bite
☐ Inflicted by staff	☐ Equipment	☐ Motor Vehicle
☐ Inflicted by peer	☐ Restraint-Related	☐ Seizure
☐ Inflicted by other	☐ Transfer/ Handling	☐ Other
☐ Environmental	☐ PICA/ Eating Non-food items	☐ Unknown

(54A) If Other Specify:

(55) Brief Description of the Injury Including Cause and Factors:

(56) Type of Injury: *Check all that apply*

☐ Abrasion/Cut	☐ Burn	☐ Head Injury	☐ Sprain/Strain
☐ Bite	☐ Choking	☐ Poison	☐ Internal
☐ Bruise	☐ Fracture	☐ Puncture	☐ Other

(56A) If Other, Specify:

(57) Body Part Affected by Injury: *Check all that apply*

☐ Toe	☐ Hip	☐ Neck	☐ Ear	☐ Wrist
☐ Foot	☐ Genitals	☐ Head	☐ Mouth	☐ Hand
☐ Ankle	☐ Front Torso	☐ Face	☐ Shoulder	☐ Finger
☐ Knee	☐ Back Torso	☐ Eye	☐ Arm	☐ Other
☐ Leg	☐ Internal Organs	☐ Nose	☐ Elbow	

(57A) If Other Specify:

Final Report: Finalization

*(58A) Name of person finalizing report:

*(58B) Position:

*(58C) Signature:

(58D) Telephone: (58E) Date/Time of Review:

DATE TIME

DMR Incident Report: Management Review (this page to be completed by DMR)

Individual: First Name: Last Name:

*(1) Area Office/Facility Review
Completed By:

*(2) Position:

*(3) Should this Minor Review Incident be Treated as a Major Review Incident: ☐ YES ☐ NO ☐ N/A

*(4) Review Status: ☐ Approved ☐ Not Approved

(5) Primary Reason For Non-Approval:
☐ Inadequate Action Steps
☐ Incorrect Categorization
☐ Additional Information Needed
☐ Other

(6) Follow Up Date if Not Approved:
(7) Comments Recommendations:

(8) Date Closed:

(9) Closed By: (10) Position:

Management Review for Major Incidents – Regional Office/Asst. Comm. Facilities Review

*(1) Regional Office/Asst. Comm. For Facilities Review Completed By:

*(2) Position:

*(3) Review Status: ☐ Approved ☐ Not Approved

(4) Primary Reason For Non-Approval:
☐ Inadequate Action Steps
☐ Incorrect Categorization
☐ Additional Information Needed
☐ Other

(5) Follow Up Date if Not Approved:

(6) Comments Recommendations:

(7) Date Closed:

(8) Closed By: (9) Position: